UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Cinryze

Program	Prior Authorization
Medication	Cinryze® (C1 esterase inhibitor, human)
Markets in Scope	Arizona, Hawaii, Nevada, Maryland, New Jersey, New York, New York EPP, Pennsylvania-CHIP, Rhode Island, California, South Carolina
Issue Date	3/2013
Pharmacy and Therapeutics Approval Date	7/2020
Effective Date	9/2020

1. Background:

Cinryze is a plasma-derived C1 esterase inhibitor (human) indicated for routine prophylaxis against angioedema attacks in adults, adolescents, and pediatric patients (6 years of age and older) with hereditary angioedema (HAE).[1]

2. Coverage Criteria:

A. Initial Authorization

1. Cinryze will be approved based on **all** of the following criteria:

a. Diagnosis of hereditary angioedema (HAE) as confirmed by **one** of the following:

(1) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by **one** of the following (per laboratory standard):
(a) C1-INH antigenic level below the lower limit of normal
(b) C1-INH functional level below the lower limit of normal

-OR-

(2) HAE with normal C1 inhibitor levels and **one** of the following:
(a) Confirmed presence of a FXII, angiopoietin-1 or plasminogen gene mutation
(b) Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

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-AND-

b. **All** of the following**:**

(1) Prescribed for the prophylaxis of HAE attacks

-AND-

(2) Not used in combination with other approved C1 esterase inhibitors indicated for prophylaxis against HAE attacks (e.g., Haegarda)

-AND-

(3) Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Cinryze

-AND-

c. **One** of the following:

(1) Submission of medical records documenting a history of failure, contraindication, or intolerance to Haegarda (C1 esterase inhibitor, human)

-OR-

(2) Patient is currently on Cinryze therapy.

-AND-

d. Prescribed by **one** of the following:

(1) Immunologist
(2) Allergist

Authorization of therapy will be issued for 12 months.

B. Reauthorization

1. **Cinryze** will be approved based on **all** of the following criteria:

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a. Documentation of positive clinical response, defined as a clinically significant reduction in the rate and/or number of HAE attacks, while on Cinryze therapy

-AND-

b. Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyr, Ruconest) as determined by claims information, while on Cinryze therapy

-AND-

c. **Both** of the following:

(1) Prescribed for the prophylaxis of HAE attacks

-AND-

(2) Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Haegarda, Takhzyro)

-AND-

d. Prescribed by **one** of the following:

(1) Immunologist
(2) Allergist

Authorization of therapy will be issued for 12 months.

3. Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Cinryze [package insert]. Lexington, MA: Shire ViroPharma Biologics, Inc.; June 2018.
2. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. Allergy. 2018 Jan 10.

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3. Wu, E. Hereditary angioedema with normal C1 inhibitor. In: UpToDate, Saini, S (Ed), UpToDate, Waltham, MA, 2020.

Program	Prior Authorization –Cinryze (C1 esterase inhibitor, human)
Change Control	
Date	Change
3/2013	New pharmacy/medical guideline
9/2014	Cinryze: Changed prophylaxis "of" to "against" HAE attacks, changed history of failure, contraindication, or intolerance of "alkylated androgen (eg, danazol)" to "17-alpha alkylated androgen (eg, danazol, oxandrolone) or Antifibrinolytics (eg, aminocaproic acid, tranexamic acid)", and added continuation of prior therapy for patients who are being treated prophylactically. For the off-label treatment indication, added "Not used in combination with other approved treatments for acute HAE attacks (eg, Berinert, Firazyr, Kalbitor or Ruconest)." Berinert: Added "Not used in combination with other approved treatments for acute HAE attacks (e.g. Firzayr, Kalbitor or Ruconest)." Added new criteria for Ruconest, a newly approved C1 esterase inhibitor (recombinant), mirroring Firazyr and Berinert, with an authorization duration of 12 months: • Diagnosis of HAE • For the treatment of acute HAE attacks • Not used in combination with other approved treatments for acute HAE attacks (eg, Berinert, Firzayr, or Kalbitor) • Prescribed by an immunologist, allergist, or rheumatologist
7/2016	Updated clinical criteria to align with Employer and Individual medical necessity, except prescriber requirement. Cinryze, Berinert, Ruconest separated into individual policies to align with Employer and Individual. Updated policy to new template.
7/2017	Annual review. Updated references.
7/2018	Updated clinical criteria to align with Employer and Individual Medical Necessity program. Updates include adding criteria around diagnosis, removal of step therapy medications, and adding prescriber attestation and not used in combination with Haegarda. Updated references.

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7/2019	Added step through Haegarda if the request is for prophylaxis use. Added step through Berinert and Firazyr if the request is for treatment of acute attacks. Added reauthorization criteria.
7/2020	Annual review. Aligned criteria with acute and prophylactic therapies. Removed off-label use for acute attacks. Added additional clinical programs section. Updated references.

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